Kansas Medical Assistance Program
PA Phone 800-933-6593
PA Fax 800-913-2229

Amerigroup
PA Pharmacy Phone 800-454-3730
PA Pharmacy Fax 844-512-8999
PA Medical Phone 855-201-7170
PA Medical Fax 855-363-0728

Sunflower
PA Pharmacy Phone 877-397-9526
PA Pharmacy Fax 866-399-0929
PA Medical Phone 877-644-4623
PA Medical Fax 888-453-4756

UnitedHealthcare
PA Pharmacy Phone 800-310-6826
PA Pharmacy Fax 866-940-7328
PA Medical Phone 866-604-3267
PA Medical Fax 866-943-6474

IMMUNOMODULATORS FOR INFLAMMATORY CONDITIONS PRIOR AUTHORIZATION FORM

Complete form in its entirety and fax to the appropriate plan's PA department.
For questions, please call the pharmacy helpdesk specific to the member's plan.

CHECK ONE: ☐ **Drug dispensed from a pharmacy (pharmacy benefit)**
☐ **Drug administered in an office or outpatient setting (medical benefit)**

MEMBER INFORMATION		
Name:	Medicaid ID:	
Date of Birth:	Gender:	
PRESCRIBER INFORMATION		
Name:	Medicaid ID:	
NPI:	Phone:	Fax:
Address:	City, State, Zip Code:	

The following medications require Prior Authorization (PA). Medications requiring PA may have to meet clinical **and** Non-Preferred PA criteria before the claim may be considered for payment.

Please provide the required data for the specific drug being requested. Below is a list of links you may find helpful in determining the required information:

- Clinical PA criteria: http://www.kdheks.gov/hcf/pharmacy/pa_criteria.htm
- KS Preferred Drug List (PDL): http://www.kdheks.gov/hcf/pharmacy/download/PDLList.pdf
- Non-Preferred, PA Required PDL criteria: http://www.kdheks.gov/hcf/pharmacy/download/NonPreferred_PA_Criteria_for_PDL_Drugs.pdf
- KS NDC lookup tool: https://www.kmap-state-ks.us/Provider/PRICING/NDCSearch.asp
- KS HCPCS lookup tool: https://www.kmap-state-ks.us/Provider/PRICING/HCPCSSearch.asp

Note: Any area not filled out will be considered not applicable to this PA & may affect the outcome of this request.

Instructions to complete this form:
1. Complete **the Member/Prescriber Information** portion above and **Sections I and II** for **ALL** requests.
2. Complete **Section III** for **medication-specific safety criteria** if applicable to the medication requested.
3. Complete **Section IV** if this request is a **renewal**.
4. Complete **Section V** if the requested medication is also a **non-preferred medication** on the Kansas Medicaid PDL.
5. Prescriber - **Sign and date** the form prior to submission.

SECTION I: MEDICATION REQUESTED

Select the appropriate medication(s) for this request:

☐ Actemra ☐ Amevive ☐ Amjevita ☐ Cimzia ☐ Cosentyx ☐ Cyltezo ☐ Enbrel ☐ Entyvio ☐ Erelzi ☐ Humira ☐ Ilaris
☐ Ilumya ☐ Inflectra ☐ Ixifi ☐ Kevzara ☐ Kineret ☐ Olumiant ☐ Orencia ☐ Otezla ☐ Remicade ☐ Renflexis ☐ Rituxan
☐ Siliq ☐ Simponi ☐ Simponi Aria ☐ Stelara ☐ Taltz ☐ Tremfya ☐ Tysabri ☐ Xeljanz ☐ Xeljanz XR

NDC/HCPCS (J Code)	Strength	Dosage Form	Quantity	Directions for Use

Indication/Diagnosis:

Is the requested medication being prescribed for an FDA-approved indication? ☐ YES ☐ NO

Indication: _____

ICD-10: _____

Patient's weight: _____ ☐ lbs ☐ kg

SECTION II: CLINICAL INFORMATION – For ALL Requests

1. Is this a new or renewal request for this medication?
   - ☐ New
   - ☐ Renewal – Proceed to section IV.

PATIENT NAME:		MEDICAID ID:	

SECTION II (CONT.): CLINICAL INFORMATION – For ALL Requests

2. Please document the prescribing physician's specialty.

☐ Dermatologist ☐ Gastroenterologist ☐ Ophthalmologist ☐ Rheumatologist ☐ Other

A. If other, has the prescribing provider consulted with one of the provider specialties listed above in question 2?

☐ YES – If YES, please document the provider's name, specialty and date of consult:

Provider name: _____ Specialty: _____ Date of Consult: _____

☐ NO

3. Has the patient been evaluated for latent tuberculosis (TB) with a TB skin test? ☐ YES ☐ NO

A. If YES, what was the result and date of the most recent TB test?

Result: ☐ Positive ☐ Negative Date: _____

4. Will the requested medication be used concurrently with another biologic agent or janus kinase inhibitor? ☐ YES ☐ NO

5. Has the patient taken a biologic agent or janus kinase inhibitor in the past 30 days? ☐ YES ☐ NO

A. If YES, specify the previous agent used: _____

6. Please list all medications the patient has previously tried and failed for treatment of this diagnosis.

*Specify medication name, reason for discontinuation (i.e. inadequate response, allergy, contraindication, intolerance) and dates of previous trial.

Medication name	Reason for Discontinuation	Dates of trial

7. Please list all medications the patient will use in combination with the medication requested for the treatment of this diagnosis.

Medication name(s): _____

SECTION III: MEDICATION-SPECIFIC SAFETY CRITERIA

Select the requested medication from the list below and complete the medication-specific safety criteria questions that follow. If the medication for this request is not listed below, skip section III.

☐ **ACTEMRA** – Does the prescriber attest to each of the following criteria? ☐ YES ☐ NO

1. Prior to initiation of therapy, the patient has absolute neutrophil count (ANC) $\geq$ 2000 cells/mm^3, platelet count $\geq$ 100,000 cells/mm^3, normal LFTs (ALT/AST: 1.5 times the upper-limit of normal is considered abnormal for therapy initiation).
2. Documentation of ANC, platelets, LFTs and lipid parameters will be completed 4-8 weeks after initiation of therapy, then every 12 weeks for ANC, platelets, LFTs and every 24 weeks for lipid parameters.
3. IV formulation only: Dose does not exceed 800 mg per IV infusion.

☐ **AMEVIVE** – Does the prescriber attest to each of the following criteria? ☐ YES ☐ NO

1. Patient does not have a diagnosis of HIV or AIDS.
2. Prior to initiation of therapy, patient's most recent CD^4 count is > 250 cells/uL.

☐ **ILARIS** – Does the prescriber attest to the following criteria? ☐ YES ☐ NO

1. Patient is not taking another IL-1 blocking agent (i.e. Arcalyst) within the past 30 days.

☐ **KEVZARA** – Does the prescriber attest to each of the following criteria? ☐ YES ☐ NO

1. Patient does not have any of the following laboratory abnormalities prior to initiation of therapy:
   - ANC <2,000 cells/mm^3, platelets <150,000 cells/mm^3, liver transaminases > 1.5 times the upper limit of normal
2. Patient does not have active hepatic disease or hepatic impairment (including positive HBV or HCV serology).

☐ **KINERET** – Does the prescriber attest to the following criteria? ☐ YES ☐ NO

1. Patient has a complete blood count, including neutrophil count, prior to therapy initiation.

☐ **OLUMIANT** – Does the prescriber attest to each of the following criteria? ☐ YES ☐ NO

1. Patient does not have any of the following laboratory abnormalities prior to therapy initiation:
   - Hemoglobin < 8 g/dL, absolute lymphocyte count < 500 cells/mm^3, ANC < 1,000 cells/mm^3
2. Medication will not be used in combination with potent immunosuppressants, such as azathioprine and cyclosporine.

☐ **RITUXAN** – Does the prescriber attest to the following criteria? ☐ YES ☐ NO

1. Prior to initiation and every 2-4 months, the following laboratory tests will be completed for this patient: CBC and platelets.

PATIENT NAME:		MEDICAID ID:	

SECTION III (CONT.): MEDICATION-SPECIFIC SAFETY CRITERIA

☐ **SILIQ** – Does the prescriber attest to each of the following criteria? ☐ YES ☐ NO

1. Patient does not have concurrent Crohn's disease.
2. Prescriber, pharmacy and patient are enrolled in the REMS program.

☐ **STELARA** – Does the prescriber attest to each of the following criteria? ☐ YES ☐ NO

1. For all indications, except Crohn's disease: Dose does not exceed 45 mg/injection.
   - If the prescriber is seeking 90 mg per dose, documentation of the patient's weight and/or that the 45-mg dose has not been efficacious is required.

☐ **TALTZ** – Does the prescriber attest to the following criteria? ☐ YES ☐ NO

1. Patient does not have concurrent Crohn's disease or ulcerative colitis.

☐ **TYSABRI** – Does the prescriber attest to the following criteria? ☐ YES ☐ NO

1. Prescriber, patient and infusion center are registered with the TOUCH prescribing program.
2. Medications will not be used in combination with immunosuppressants.

☐ **XELJANZ** – Does the prescriber attest to the following criteria? ☐ YES ☐ NO

1. Prior to initiation of therapy and every 3 months, the patient will have the following laboratory tests checked:
   - Lymphocyte count, ANC and hemoglobin.
2. Medication will not be used in combination with potent immunosuppressants, such as azathioprine and cyclosporine.

☐ **XELJANZ XR** – Does the prescriber attest to the following criteria? ☐ YES ☐ NO

1. Prior to initiation of therapy and every 3 months, the patient will have the following laboratory tests checked:
   - Lymphocyte count, ANC and hemoglobin.
2. Medication will not be used in combination with potent immunosuppressants, such as azathioprine and cyclosporine.

SECTION IV: RENEWAL

1. Does the prescriber attest that the patient has received clinical benefit from continuous treatment with the requested medication?
   ☐ YES ☐ NO
2. Does the prescriber attest that all additional medication-specific safety criteria (defined within the clinical criteria and above in section III) is met? ☐ YES ☐ NO

SECTION V: NON-PREFERRED MEDICATION

1. Is the medication requested a non-preferred medication on the Kansas Medicaid preferred drug list (PDL)? ☐ YES ☐ NO

   A. If YES: Does the patient have a documented clinical rationale for using a non-preferred medication that is supported by the product labeling as specified in the Immunomodulators for Inflammatory Conditions clinical criteria?
   ☐ YES ☐ NO

   Please submit documentation of clinical rationale to support the use of the requested non-preferred medication.

   _____

   _____

   _____

PRESCRIBER SIGNATURE

☐ **I have completed all applicable boxes and attached any required documentation for review, in addition to signing and dating this form.**

_____ _____

Prescriber or authorized signature **Date**

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.